Maternal Health Outcome Summary

Client ID: _____

Admission ID: _____

Client's name *(first, middle, last)*: _____ Maiden name: _____

Birth date: ____/____/____ Client alias: _____

Street address: _____ Apt# _____

City: _____ State: _____ Zip code: _____

Cell phone: _____ Alternate phone: _____

Discharge date: _____/_____/_____

Were services terminated prior to delivery? ☐ yes ☐ no

If yes, reason:

☐ client moved out of area	☐ transferred to another contractor
☐ miscarriage/fetal death	☐ transferred to other care
☐ MH services refused	☐ unable to locate
☐ spontaneous abortion	☐ Other specify _____

Were services terminated prior to postpartum follow up? ☐ yes ☐ no

Will client receive postpartum home visit? ☐ yes ☐ no

Postpartum followup: ☐ care coordination ☐ clinic visit ☐ refused

Date postpartum referral was sent: _____/_____/_____ Date of postpartum home visit completion: _____/_____/_____

Primary Payment Source: *(enter option from payment source table below)* _____

Secondary Payment source: *(check all that apply)*

☐ Medicare	☐ private insurance	☐ uninsured
☐ Medicaid/Title XIX	☐ self-pay/sliding scale	☐ other specify _____
☐ presumptive eligibility	☐ Title V	

WIC certified? ☐ yes ☐ no ☐ unknown

Delivery date _____/_____/_____

Multiple birth? ☐ yes ☐ no How many births? _____

Complications with this pregnancy? ☐ yes ☐ no

Did mother begin breastfeeding? ☐ yes ☐ no ☐ unknown

Pregnancy Comments:

_____

_____

_____

_____

_____

_____

Client Name: _____ Birth Date: _____Medicaid ID: _____

Child Information

	Child #1	Child #2 (twin)	Child #3 (triplet)
Child's name (first, middle, last)			
Gender	☐ male ☐ female	☐ male ☐ female	☐ male ☐ female
Birthdate	____/____/____	____/____/____	____/____/____
Gestational age at birth (weeks)			
Outcome	☐ live birth ☐ stillborn	☐ live birth ☐ stillborn	☐ live birth ☐ stillborn
Type of delivery	☐ vaginal ☐ cesarean	☐ vaginal ☐ cesarean	☐ vaginal ☐ cesarean
Birth weight (grams)			
Length			
ID ID Type			
Abnormalities or health problems	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Describe health problem			
Has child died?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Date of death	____/____/____	____/____/____	____/____/____

Add pages if necessary for multiple births

Does client smoke cigarettes? ☐ yes ☐ no ☐ unknown

How many cigarettes per day?

☐ <1	☐ 10-20	☐ more than 2 packs
☐ 1-5	☐ 1 pack	☐ unknown
☐ 5-10	☐ 1-2 packs	

Does client drink alcohol? ☐ yes ☐ no ☐ unknown

How often ? ☐ never ☐ less than 1 drink/week ☐ 2-6 drinks/week ☐ 1 drink/day ☐ more than 1 drink/day

Does client use illicit drugs? ☐ yes ☐ no ☐ unknown

What drugs ?

☐ cocaine	☐ heroin	☐ unknown
☐ crack	☐ marijuana	☐ other
☐ crank	☐ methamphetamine	specify _____

Attending parenting education classes? ☐ yes ☐ no

Family planning arrangements:

☐ birth control pills	☐ natural family planning	☐ ring
☐ condom	☐ Nexplanon	☐ three month injection (Depo)
☐ IUD	☐ patch	☐ none
		☐ other specify _____

Client Name: _____ Birth Date: _____Medicaid ID: _____

Does client have a primary medical care provider? (medical home) ☐ yes ☐ no ☐ unknown

Did client have dentist visit during pregnancy? ☐ yes ☐ no ☐ unknown

If yes, what was reason(s) for dentist visit? ☐ Regular check-up or teeth cleaning ☐ Treatment for pain or other problem ☐ unknown

Dental payment source:

☐ Medicaid/Title XIX	☐ self-pay/sliding scale	☐ other specify _____
☐ presumptive eligibility	☐Title V	
☐ private dental insurance	☐ uninsured	

Does client understand the need for her child to have a dentist visit by age 1? ☐ yes ☐ no

Does client have any oral concerns or problems? ☐ yes ☐ no

Specify: _____

Dental Comments:

_____

_____

_____

Comments:

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	Name	Date
Outcome form completed by:		
Data entered by:		
Quality assurance inspection:		